No. 12114

In the United States

COURT OF APPEALS

for the Ninth Circuit

MICHIGAN MILLERS MUTUAL FIRE INSURANCE COMPANY, a corporation,

Appellant,

vs.

GRANGE OIL COMPANY OF LINN AND BENTON COUNTIES, a co-operative corporation,

Appellee.

Appeal from United States District Court for the State of Oregon.

BRIEF OF APPELLANT

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SUBJECT INDEX

TABLE OF CASES CITED

STATUTES

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JURISDICTION

This suit, brought by the appellee in the state court in Oregon by complaint filed against appellant (Tr. 2-7), was removed to the United States District Court upon petition of the appellant, defendant below, pursuant to Title 28, U.S.C.A. Sec. 41 (1b), on the ground

of diversity of citizenship. Plaintiff is a corporation organized under the laws of Oregon and defendant is a corporation organized under the laws of Michigan (Tr. 2). The amount claimed by the complaint exceeded $3,000.00 exclusive of interest and costs (Tr. 7). The existence of such diversity and the existence of the jurisdictional amount were admitted below (Tr. 26) and no jurisdictional question is involved either under Title 28, U.S.C.A. Sec 41 (1b) which governed when the cause was removed from the state court to the United States District Court for the District of Oregon, or under Title 28, U.S. Code, Sec. 1332, (a1) in force when the judgment of the District Court was entered. Since there is no question as to the efficacy of the removal proceedings the Petition, notice, undertaking and order were not included in the printed record; they are however included in the Transcript of record from the District Court.

This appeal, under Title 28, United States Code, Judiciary and Judicial Procedure, Sec. 1291, is from a judgment against the defendant for $16,356.20 plus interest and $1500.00 attorneys' fees entered on September 20, 1948 (Tr. 63-64). Notice of appeal was filed on October 14, 1948 (Tr. 64-65) within the thirty day period permitted by Sec. 2107, Title 28, United States Code, Judiciary and Judicial Procedure, which became effective September 1, 1948.

STATEMENT OF CASE

The effect of the judgment in the present case is to give to the plaintiff an additional $16,666.67 of fire insurance coverage for which the plaintiff, as insured, would not have paid a premium if the loss occasioned by a fire occurring on January 9, 1947, had not happened. This result is reached by the trial court's holding that the plaintiff was not bound by its previous erroneous reports stating under oath that the amount of "non-provisional" insurance (i. e., insurance other than defendant's provisional reporting policy described below), which is deductible in determining the amount of defendant's premium, was $50,000. In this suit, the plaintiff was permitted to prove that the correct amount of non-provisional insurance was only $33,333.-00, thereby increasing by $16,666.67 the insurance under defendant's policy.

This case, therefore, involves the highly important question whether after a fire loss occurs the insured may abandon previous reports of the amount of non-provisional insurance and may show a mistake—in this case an honest one, but in the next case perhaps more doubtful—in the amount of non-provisional insurance reported, and by such showing increase the amount of insurance under the provisional reporting policy over and above the figure shown by the insured's previous sworn statements.

This result is so shocking to the conscience, so contrary to the theory of provisional reporting insurance, and so liable to future abuse in the understatement

of amounts on which premiums are computed, that this appeal is prosecuted.

The policy in suit was a provisional reporting form and the original policy, No. 133021, being plaintiff's Exhibit 1, has been transmitted by order of the District Court to this Honorable Court in lieu of setting it forth in full in the transcript of the record. The policy was originally issued to Theodore Kowalski on the 1st day of May, 1943, for a period of five years, and was assigned to the apellee in this case with the consent of the appellant.

There is no conflict in the testimony, and there is no issue of fact, as we understand it, the judgment of the trial court being held entered as a matter of law upon facts agreed to in the pre-trial order or by uncontradicted testimony.

The policy, being the standard form of fire insurance policy in use in Oregon, had attached to it the standard provisional stock form used by the appellant. The property covered by insurance was stock consisting of grain and seeds, stock in process, finished stock and all other merchandise and supplies not otherwise insured * * * while contained in the building or buildings as located and described in the "Schedule Endorsement" attached to the policy. The property which was destroyed by fire on January 9, 1947, was in the frame warehouse and seed cleaning plant known as Plant No. 2, and is Item 2 in the amended "Schedule Endorsement" dated August 19, 1946.

The limit of insurance subject to any one fire at Plant No. 2 was $145,000.00, and the limit of liability under appellant's policy, subject to any one fire at this location, was also $145,000.00, and the full limit of liability, or 100% of the limit of insurance up to $145,-000.00 afforded by the provisional policy, was assumed by the appellant.

Since this is a provisional policy, the actual amount of insurance applicable to a loss as of the date of the fire is determined by a formula contained in the provisional stock form attached to the policy, the limit of liability being important only as determining the maximum liability appellant can have by reason of a fire in Plant No. 2. As the loss did not approximate the limit of liability, the need of further considering it is eliminated.

As the pertinent provisions of the policy necessary for the decision in this case are, in our opinion, found in the standard provisional stock form (Tr. 19-24, 57-62), we will, for the convenience of the Court, set them forth here.

Paragraph 2 provides generally that any specific amount of insurance named in the policy is not only provisional, and that the amount of insurance afforded by the policy at any time "shall be determined by the procedure outlined in paragraph 5" (Tr. 58).

Paragraph 3 reads as follows:

> "The insured expressly agrees to file with this insurer, or its designated agent, after the close of the insured's business upon the last Saturday of

each month, and before a loss shall have occurred, a true statement in writing of the value (as defined in paragraph 4) of the stock covered hereunder at each location described in the 'Schedule Endorsement', as of the close of business on each Saturday of such month; and, if the insured so elect, such amount in addition thereto as the insured shall estimate as sufficient to cover errors or omissions in ascertaining such value; *and the insured shall also include in such statement the amount of any non-provisional insurance on said stock against the hazards covered hereunder.*" (Italics supplied.)

Paragraph 4 defines the word "Stock" as used in the form, and says:

"It is further agreed that wherever the term 'Value' is used in this form it shall apply in the manner set forth in sections (4a), (4b) and (4c) below at the location and at the time when such ascertainment of value is required by the conditions of this policy:"

There is, as we understand, no question but what the value of the stock destroyed was determined in accordance with said sections (4a), (4b) and (4c). (Tr. 58-59.)

Paragraph 5 contains the formula under which the amount of insurance applicable at the time of the loss is determined. It reads as follows:

"5. The Amount of Insurance under this form, at any time, at any location described in the 'Schedule Endorsement,' shall be determined by following the formula set forth in Sections 5A, 5B, 5C and 5D.

Section 5 A. As of the time at which insurance in force is to be determined, acertain the value,

as defined in Paragraph 4, in such location.

Section 5B. Deduct from this value the amount of any non-provisional insurance against the hazards covered hereunder on said stock.

Section 5C. If through error, omission or otherwise the statement of value last filed by insured in accordance with the provisions of Paragraph 3 shall be less than the actual value as ascertained upon the same Saturdays for which said statement of value was filed, the amount as determined by Sections 5A and 5B shall be further reduced by the difference between the average of value so filed (including estimated amount, if any) and the average of actual values as ascertained for the same Saturdays.

Section 5D. 1. If the amount determined by Sections 5A, 5B and 5C is less than the 'Limit of Insurance' named in the 'Schedule Endorsement,' at such location, the amount thus determined shall be the 'Amount of Insurance under this form.'

2. If the amount determined in Sections 5A, 5B and 5C is equal to or greater than the 'Limit of Insurance' named in the 'Schedule Endorsement' at such location, the amount of the 'Limit of Insurance' so named shall be the 'Amount of Insurance under this form.' "

Paragraph 7 provides that the statement under Paragraph 3, shall be used for the determination and adjustment on each anniversary date of the policy of the premium earned, as follows:

"7. The premium earned under this policy shall be determined and an adjustment thereof made on each anniversary date hereof, or upon termination or cancellation of this policy, based on the average of values filed with this insurer, or its designated agent, as required in Paragraph 3; but *no per-*

> *mium shall be charged* on any values in excess of the amount named as the 'Limit of Liability Under This Policy,' nor *on any value protected by non-provisional insurance against the hazards covered hereunder reported in accordance with Paragraph 3.*" (Italics supplied. Tr. 22.)

There is no provision in said "Standard Provisional Stock Form" for any audit by the insurer of the insured's books, records or other policies of insurance. It is admitted in the present case that the insured had not paid a premium to appellant on that $50,000 of value represented by non-provisional or specific insurance reported by the appellee in its statement of values under Paragraph 3.

Paragraph 8 of the form reads as follows (Tr. 61):

> "It shall be the privilege of the insured to make *any changes* desired by him in the last previously filed statement required in Paragraph 3 *but such changes shall not be effective unless made* in writing and filed with this insurer or its designated agent *before a loss shall have occurred.*" (Italics supplied.)

Paragraph 14 is the co-insurance clause in the policy and it reads as follows:

> "Co-Insurance Clause: In consideration of the acceptance by the insured of the following Co-insurance Clause a reduction from the established premium rate of $ —— to —— has been allowed on this insurance:
>
> In consideration of the rate and/or form under which this policy is written it is expressly stipulated and made a condition of this contract that the insured shall at all times maintain contributing in-

surance on each item of property insured by this policy to the extent of at least 100% of the actual cash value at the time of the loss, and that failing to do so, the insured shall to the extent of such deficit bear his, her or their proportion of any loss."

This policy was specifically designed to protect fluctuating values of grain coming into the elevator (Tr. 124) and is particularly adaptable to the needs of an insured with varying values. For example, during November, 1946, the insured's values in Plant No. 2 reached a high of $156,402.57 on Saturday of the first week and a low of $150,703.62 on Saturday of the fifth week (Tr. 46). In July, 1946, when all of the locations were grouped, the value rose from $45,000.00 on Saturday of the first week to $244,328.29 on Saturday of the fourth week (Tr. 45).

Under the obligation imposed by paragraph 3 of the form, the appellee filed monthly reports showing the actual cash values for each Saturday of the months of August, September, October and November, 1946, and in each such monthly report listed $50,000.00 of non-provisional insurance. These monthly reports were introduced as Defendant's Exhibit 22 (Tr. 41) and by order of Court the originals thereof were transmitted to this Court. They are summarized in the printed transcript (pp. 44-46). In each report of values and in compliance with the specific requirement of Paragraph 3 by which the appellee agreed to file a true statement in writing, including in such statement the amount of any non-provisional insurance on its stock, appellee

reported $50,000.00 of non-provisional stock insurance on the contents of Plant No. 2 for the months of August, September, October and November, 1946. Upon receipt of each of these reports, the non-provisional insurance of $50,000.00 reported was deducted from each Saturday value and the difference was posted upon the provisional ledger sheet of the defendant as the amount of its insurance (Deft.'s Ex. 24, Tr. 43). Defendant's computation of the premium earned is predicated upon the figures appearing on its provisional ledger sheet and for each of the weeks ending August 24, 1946, through November 30, 1946, which was the last report of values prior to the loss, the plaintiff was given credit for $50,000.00 of non-provisional stock insurance covering on the contents of Plant No. 2, which amount was deducted from the values on hand before the basis for premium charge was reached in accordance with the terms of Paragraph 7.

It is conceded that, although the appellee attempted to obtain $50,000.00 of non-provisional insurance, it actually, because of an unexplained mistake, obtained insurance upon this specific location in the amount, only, of $33,333.33. (Tr. 90, 91, 98, 101, 102.) The good faith of the appellee in reporting $50,000.00 of non-provisional insurance is not questioned, but neither is it questioned that believing that it did have $50,000.00 of non-provisional insurance covering the contents of Plant No. 2, the appellee in all of the reports filed pursuant to Paragraph 3 of the form so reported.

The importance of the non-provisional, or specific

insurance was explained to the insured in two letters within the six month period before this loss. The report of values filed by the appellee for the month of June, 1946, reported no values on hand (Tr. 45). On the 10th day of July, 1946, the appellant wrote to the appellee and said, in part:

> "It seems rather strange that a business of this size would have no values on stock unless, of course, you have some specific insurance which was mentioned in some correspondence some time ago. With the thought in mind that this provisional policy is not fully understood, we would call your attention to the fact that under the terms and requirements of that policy all values in the house must be reported to us. *Then if there is any specific insurance, it is shown out in the last column and if it exceeds the actual values then there would be no liability under our policy.*
>
> "Therefore, on the basis of the policy coverage and the requirements, we will appreciate it if you will make up a new form for June showing the total values in the plant and the amount of specific insurance in the last column. That will enable us to make the proper entry here." (Italics supplied. Deft.'s Ex, 25, Tr. 48.)

On November 24, 1946, appellant again wrote the appellee—this time about the report of values for October (Tr. 45)—speaking of $50,000.00 of specific insurance on Plant No. 1 as being unnecessary, and as to Plant No. 2, saying:

> "On Item 2 you are still over our limit but a portion of the specific insurance could be discontinued if you want to do so." (Deft.'s Ex. 26, Tr. 49.)

On the 9th day of January, 1947, Plant No. 2 burned. It was agreed that the value of the stock destroyed was $121,410.31, and that there was salvage of $753.89. It was also agreed that the actual amount of specific insurance which plaintiff had in each of the months of August, September, October and November was not $50,000.00 as had been reported, but $33,333.33. (Admitted Fact 6 in Pre-trial Order, Tr. 28.)

The fire having occurred, and the amount of the loss having been determined, it was necessary to determine the amount of insurance afforded under the form.

While we feel that if we had been making the computation of the amount of insurance afforded the appellee by this policy we would have simply said that there was a loss agreed to of $121,410.31 and there was non-provisional insurance of $50,000.00, so that there was insurance afforded by appellant's policy of $71,-410.31, we know that the proper way to determine the figure was to follow the formula in the contract and not take even obvious shortcuts.

In the pre-trial order and upon the trial of the case the appellant contended, and upon this appeal contends, that the amount of insurance applicable to the loss of January 9, 1947, under the policy issued by it should be determined as follows:

Sec. 5A	
Actual value of the stock on January 9, 1947, as determined by the records of plaintiff	$121,410.31

Sec. 5B	
Deduct amount of non-provisional or specific insurance ACTUALLY in effect	33,333.33
	88,076.98
Sec. 5C (1)	
The actual values and amounts as determined from the records of plaintiff for the month of November, 1946, the last month for which a report of actual cash value was filed prior to loss	$153,593.49
Less actual, specific insurance ACTUALLY in effect	33,333.33
Actual value not covered by specific insurance	$120,260.16
Sec. 5C (2)	
Values and amounts as determined from report of November, 1946:	
Value of stock	$153,593.49
Less specific insurance reported	50,000.00
Values reported not covered by specific insurance	$103,593.49
Sec. 5C (3)	
Actual value not covered by specific insurance	$120,260.16
Less value reported not covered by specific insurance	103,593.49
Values under-reported	$16,666.67
Sec. 5C (4)	
Actual value of the stock on January 9, 1947, as determined by the records of plaintiff	$121,410.31

Deduct amount of non-provisional, or specific insurance ACTUALLY in effect on January 9, 1947	33,333.33
	88,076.98
Less values under-reported	16,666.67
Sec. 5D Amount of provisional insurance in force under the policy	$71,410.31

Through the application of the co-insurance clause and by reason of the salvage, which, of course, was not taken into consideration in the determination of the amount of insurance afforded by appellant's policy, the amount which the appellant felt it was liable to its insured was determined to be $70,966.89 and this amount appellant paid to the appellee promptly (Tr. 55) with the agreement that said payment was without prejudice to the rights of either the appellant or the appellee. (Tr. 27, Admitted Fact 5.)

Upon this evidence the learned trial judge filed a memorandum decision saying:

> "I don't feel that a clause in an insurance contract should be given the legal effect of a warranty, unless the policy makes it plain that this was intended. It is not plain in this case. Therefore, testing the situation by the usual rule of damages, plaintiff is liable for the premium, while defendant remains liable for the insurance." (Tr. 50).

Judgment was entered against the defendant and in favor of the plaintiff in the principal sum of $16,356.20, together with interest and $1500.00 attorneys' fees (Tr. 63). The appellant has taken this appeal from that judgment.

SPECIFICATION OF ERRORS

The Court erred:

1. In holding in Conclusion of Law No. II that plaintiff's obligation to report the amount of specific insurance in force on the goods covered by the appellant's policy did not constitute a promissory warranty.

2. In holding in Conclusion of Law No. III that the plaintiff's error in reporting the amount of specific insurance in effect did not relieve defendant from liability to pay the full amount of the plaintiff's loss less the actual amount of specific insurance carried by the plaintiff.

3. In holding in Conclusion of Law No. IV that the amount of loss for which defendant became liable to the plaintiff was $87,323.09, instead of $70,966.89, and in concluding further that there was a balance due plaintiff from defendant in the amount of $16,356.20.

4. In holding in Conclusion of Law No. V that plaintiff was entitled to a judgment against the defendant in the sum of $16,356.20, together with interest, costs and attorneys' fees.

5. In failing to make a Conclusion of Law that the plaintiff's error in reporting to defendant the amount of specific insurance in effect reduced the amount of insurance by the amount of the error in the report.

6. In failing to make a Conclusion of Law that the defendant had by its payment to the plaintiff of

$70,966.89 discharged its full obligation under its policy to the plaintiff.

7. In failing to conclude as a matter of law that the defendant was entitled to a judgment.

8. In entering judgment in favor of the plaintiff and against the defendant.

SUMMARY OF ARGUMENT

I

The Judgment In This Case Violates The Theory Underlying Reporting Forms of Insurance

A reporting form of policy affords to an insured with varying or fluctuating values an opportunity to order through his periodic reports of values sufficent insurance for his varying needs. It permits him, in effect, to buy monthly the insurance he needs instead of buying yearly enough to cover his peak loads and thus paying for amounts of insurance which he frequently does not need.

In the policy sued upon in this case the insured agreed to file with the insurer after the close of the insured's business upon the last Saturday of each month, and before a loss shall have occurred, a true statement in writing of the value of the stock covered at each location as of the close of business on each Saturday of the month and the amount of non-provisional or specific insurance on said stock. The result of true statements is insurance coverage, not to the value re-

ported, but insurance coverage which follows the values up and down so the insured has and pays for only the insurance protection it needs, providing only that the loss shall not exceed a "Limit of Liability" agreed to by the parties to the policy.

In the policy (Paragraph 7 of the form) it is provided that the premium shall be determined upon the average of the values filed but that no premium shall be charged on the amount of non-provisional insurance reported.

A discussion of the more important cases involving reporting forms of policy is contained in this first division of the argument.

As every effort was made to limit the quotations therefrom to an absolute minimum we will say only that we feel the *Wallace* case from this circuit (166 F. 2d 571) affirmed by this Court in a *per curiam* opinion, "on the grounds and for the reasons stated" in the opinion of the District Court (70 F. Supp. 193), is governing in this case. We believe that the insurer interpreted its policy as Judge Harrison and this Court held a reporting form of policy should be interpreted. There are two recent cases from the Tenth Circuit and one from the Court of Appeals of New York quoted from in the argument, which may not be further summarized.

II

The Judgment Below Disregards The Language of The Policy Involved Here

Under the terms of the policy sued upon the insured was obligated to file with the insured each month "a true statement in writing of the value of the stock covered hereunder * * * and the amount of any non-provisional insurance on any stock."

The insurer reported the value of its stock on hand accurately, but erroneously reported in each monthly report of values that it had $50,000.00 of non-provisional insurance, when in fact it had only $33,333.33. The Federal Court cases which we quote from in the first division of our argument hold that under-reporting resulted in under-insurance.

The policy provision requiring "a true statement" is a promissory warranty on the insured's part. The policy, however, does not provide for a forfeiture and none was claimed when the mistake was discovered after the fire. Instead, the appellant took the position that the reports required by the policy were in fact orders for insurance. If the values were accurately reported the assured had coverage under appellant's policy on the day of the loss up to $145,000.00 of loss over and above the $50,000.00 of specific insurance reported.

The policy of insurance also provided that the insurer could not charge a premium for any value covered by non-provisional insurance.

The insured was given the right under the policy to change its reports of value at any time prior to a loss.

It is urged that having made a contract fair and unambiguous, having eliminated the harsh consequences attendant upon a breach of warranty, the contract as made should be enforced. By over-reporting its non-provisional insurance the appellee under-reported its values. Thereby it failed to order enough insurance for its needs and it may not be permitted, after the fire, to increase the amount of insurance coverage under appellant's policy by saying, "We made a mistake and had $16,666.67 more value than we reported to you because we actually had only $33,333.33 of non-provisional insurance although we have consistently reported to you that we had $50,000.00. Now after the fire we wish to change our reports." This cannot be done under the contract.

III

The Consequence of The Untrue Statement of The Amount of Non-Provisional Insurance Is To Reduce The Amount of Insurance Available To The Insured

Upon the happening of the loss on January 9, 1947, the loss was determined to be $121,410.31. Appellant's policy being for a provisional amount, it became necessary to determine the amount of insurance coverage afforded by its policy upon that day.

The simple way to do it would be to subtract $50,000.00, the amount of non-provisional or specific insurance reported, from $121,410.31, which would give $71,410.31, but the policy had to have a formula to fit all circumstances, and under the formula in the policy the amount of insurance available under appellant's policy is determined thus:

Actual value of stock on hand January 9, 1947			$121,410.31
Actual non-provisional insurance			33,333.33
			88,076.98
Average values on hand in November		$153,593.49	
Non-provisional insurance in force		33,333.33	
Actual values not covered by non-provisional insurance		$120,260.16	
Average values on hand in November	$153,593.49		
Non-provisional insurance reported	50,000.00		
Values report for insurance and premium purposes		103,593.49	
Values under-reported			16,666.67
Amount of insurance under appellant's policy			$71,410.31

And this amount (subject to immaterial and admitted adjustments, chiefly because of salvage, which reduced it to $70,966.89) appellant paid. Having discharged in full its obligation under its policy by paying the entire amount of insurance, there should have been a judgment in its favor.

I

The Judgment In This Case Violates The Theory Underlying Reporting Forms of Insurance Such As The Provisional Stock Form Involved Here

The appellannt cannot enter upon the argument of the law applicable to the facts in this case without first commenting upon the particular form of policy involved.

A provisional or reporting form of policy has with great care been developed by the insurance companies and tailored to the needs of many businesses which from their very nature have varying or fluctuating values of stock on hand. Particularly is the policy adapted to businesses with seasonal increases or decreases. As Mr. Sankela said in his testimony:

> "It is a policy that is designed by our companies * * * to protect fluctuating values of grain as it comes into the elevator, starting in the harvest season, when it might run up to high values in a month or six weeks" (Tr. 123).

In our statement of the case we called attention to the fact that plaintiff's values in July, 1946, increased from $45,000.00 on the first Saturday to about $244,-

000.00 on the fourth Saturday (Tr. 45) and that there was a spread of almost $6,000.00 of value on the contents of Plant No. 2 between the first Saturday of November and the fifth Saturday of November (Tr. 46). In August, in this same Plant No. 2 there was a variation between the first and fourth Saturdays of approximately $32,000.00 in value (Tr. 45).

Without the reporting form of policy, an insured would necessarily have to have insurance to protect his peak values, with the result that he would be paying for insurance much of the time when the goods at risk were worth substantially less than they were at peak times or he would have to be amending his specific policy constantly. This form permits him in practice to order insurance each month. Under the terms and provisions of the policy he reports his values as of the close of business on each Saturday and he reports the amount of his non-provisional insurance. Paragraph 7 provides that the premuium shall be determined from the average of values thus reported, but no premium shall be charged on the amount of non-provisional insurance reported. Hence, the basis of the premium charged and the amount of coverage are determined from the report made under paragraph 3. If properly and honestly reported under this form, the insured's protection follows his values up or down during the period between the receipt of the reports of value and the fire. The reports of value furnish the sole basis for the computation of the insurance premium and are used in computing the amount of insurance available at the time of a fire. There is no provision in this policy for any audit by

the insurer. It is sufficient, we believe, to say that if the reports of values are made accurately the insured cannot be without insurance to the full extent of the value of his property, subject only to the limit of liability provided in the policy. In other words, if the appellee's reports for August, September, October and November, 1946, had been correct, it would have had insurance coverage available at all times up to $195,000.00, being $50,000.00 of non-provisional insurance which it reported and $145,000.00 under the appellant's policy.

Before going into further details as to the meaning and operation of the provisions of the Standard Provisional Stock Form involved here (Tr. 19-24), we think it will be helpful to examine the few cases which exist on reporting forms of insurance, as they explain the theory on which such policies are written.

There are four cases, one a very recent one from this Court, to which we would like to call the attention of this Honorable Court. The first one is the case of *Atlantic Fruit Company vs. Hamilton Fire Insurance Co.*, 251 N.Y. 98, 167 N.E. 184 (1929). The opinion is by Mr. Justice Cardozo. The policy there involved was an open policy floater with a limit of liability for the contents of any one building and yard of $25,000.00. Specific insurance was first to be deducted. The Court said:

> "The premium due to the insurer is subject to variation, with variations in the coverage. A deposit premium of $250 paid at the beginning is to be adjusted thereafter according to the value of the property at risk from day to day. 'The insured

> shall keep a daily record of the total values and locations of the property at risk,' and of the 'specific or general insurance at the close of business every day,' and 'shall forward such reports monthly to W. Ward Smith, No. 1 Liberty Street, New York City.' Upon the termination of the policy 'the amounts at risk shall be averaged according to such reports and records,' and the premium due 'shall be figured on the average amount at risk so ascertained at the annual rate of one per cent.' "

There was a provision in the policy that any error or omission in rendering the monthly report of values should not operate to the disadvantage of the assured. Because of the burden of making and determining the daily values the assured elected after some time to fix the value on hand at the end of the month, add the purchases and deduct the sales, and report the remainder as the average. It was conceded that it was inaccurate and in addition substantial values were deliberately omitted. Mr. Justice Cardozo said:

> "An insurer issuing such a policy has an interest in knowing the value and location of the property at risk to enable it to calculate the premium due from the insured, and to some extent for other purposes, as, for example, reinsurance.
>
> "An intentional ommission, if not itself a fraud, is at least such a departure from the contract as to supply an opportunity for fraud. Property so omitted will seldom be known to the insurer, and hence will seldom figure in the calculation of the premium. The insured, if there is no fire, saves the cost of the insurance, and, in the event of a loss, rectifies the omission, and declares that what was lost was at the risk of the insurer. The effect of errors and ommissions must be adjuged in the light of these and kindred possibilities."

It is that very thing that the appellee seeks to do in this case. It says, "We made a mistake, but the consequences of that mistake, in the amount of $16,563,35, we desire to pass on to you by the payment to you of a small amount in premium." The court held that an habitual understatement of property covered avoided the policy.

This decision was announced on May 28, 1929.

Within the last two years, however, there have been three cases involving reporting or provisional forms of insurance policies by the United States Courts of Appeals for the Ninth and Tenth Circuits. The first was the case of *Wallace vs. World Fire & Marine Insurance Co.,* 70 F. Supp. 193, which was affirmed by this Honorable Court on March 22, 1948, by a per curiam opinion (166 F. 2d 571) "on the grounds and for the reasons stated" in the opinion of the District Court. We therefore should examine this opinion carefully because we thnk that it is governing in this case and should have caused the trial court to find for the appellant and enter a judgment in its favor. The provisional reporting form policy in that case required monthly reports of value. Shortly before the fire, the plaintiffs reported that the property insured was worth $2,000.00. Its actual value was $28,140.00. The policy provision relative to the report of values was as follows:

> "A. It is a condition of this policy that the insured shall report to this company on the last day of each month of the policy term the exact location of all property covered hereunder, the actual cash value of such property at each location, and the amount of specific insurance in force at each lo-

cation, all as of the last day of the month. However, a grace period of thirty (30) days shall be allowed for compilation and submission of such reports to this company.

B. If at the time of any loss, the insured has failed to file with this company, reports of value as above required, this policy, subject otherwise to all its terms and conditions, shall cover only at the locations and for not more than the amounts included in the last report of values filed prior to the loss; and further, if such delinquent report is the first report of values as required to be filed, this policy shall cover only at the location specifically named herein."

The learned trial judge in speaking of the time for the report said:

"A reading of this section (B) indicates that the period of grace for the filing of reports of values under no circumstances extends to a time after the fire loss, even if it is assumed that the thirty days grace period had not expired."

This is particularly enlightening in view of the words of the policy under consideration which provides that no changes may be made in the statement—which includes non-provisional insurance—unless made in writing and filed before a loss shall have occurred. (Par. 8, Tr. 23).

The insured in the *Wallace* case corrected his values within thirty days and attempted to collect the full amount of his loss. The insurer denied all liability and the trial judge, therefore, had to consider whether the misrepresentation or concealment was material and whether the understatement breached the policy so that

the entire policy was avoided. The trial court held that the policy did not provide for forfeiture and gave judgment to the plaintiff for the value it had most recently reported prior to the fire.

This was the very construction that appellant placed upon its policy in the instant case. At no time did appellant urge that the failure to report accurately or truthfully avoided its policy, but always that the consequences of it were that the insured's own statements were binding upon it in a determination of the amount of insurance available. That amount having been determined, the appellant paid it promptly.

We wish only to quote another short excerpt from this opinion as follows:

> "Even if the statement of falsely low values would not be grounds for avoidance when the insurer protects himself with an 'honesty clause' and does not rely on its accuracy, nevertheless *some* figure must be given in order to create a base for calculating the liability after loss, and to adjust premiums. It is material that the declaration of values be within the period of grace, for if the insured could wait until the risk was past, and then understate the value of the property which had been subject to the risk, he would get the benefit of full coverage with an unjustly low premium."

The next case which had consideraion by the Circuit Court of Appeals for the Tenth Circuit was *Automobile Insurance Co. vs. Barnes-Manly Wet Wash Laundry Co.,* 168 F. 2d 381 (1948). There fraud in the underreporting of gross receipts was found by a jury. There the trial court held, as the trial judge in the present

case held, that the measure of damages for the fraud was merely the balance of the premiums actually due. On appeal, a majority of the court held that the insured had to repay to the insurer a substantial sum of money (57% of $211,410.56) which the insurance company had paid out in claims, for the reason that the insured had reported only 43% of its values and the insurance company had received only 43% of the premium which it was entitled to have. The court held (p. 385) that giving the insurer the premiums actually earned was wholly inadequate.

It is not possible to distinguish this case by saying that it has no applicability because there the plaintiff's actions were found to be fraudulent, while here the plaintiff's actions were the result of a mistake. Otherwise, what is a mistake today will be a cover for fraud tomorrow. The defendant in this case is just as much harmed by the reduction of premium paid to it, because of mere mistake, as it would have been harmed by a similar reduction due to a fraudulent overstatement of the amount of non-provisional insurance carried by the plaintiff.

The third case, also decided by the Tenth Circuit, is *Aetna Insurance Co. vs. Rhodes,* 170 F. 2d 111 (1948). In that case the first report of values had not been received and the question was whether the provisional amount of insurance stated in the policy was the amount of insurance applicable. The trial court and the court on appeal both so held. In the opinion of the United States Court of Appeals, that Court,

speaking through District Judge Broaddus, said:

> "There is, however, a penalty for over-valuation under the premium adjustment clause of the policy as the amount of the premium is computed upon the average of the valuations shown in the reports. If the insured overstates the value of the property it goes into the total from which the average is determined and the premium calculated. As a result, the insured pays a premium on property he does not possess. Such is the working of the full reporting clause, and when so understood it will be seen that the failure to report, the reportnig of over-values and the reporting of under-values carry their respective penalties. Under the rule that a policy will be reasonably construed to the benefit of the insured, no other penalty, such as forfeiture, may be presumed and none will be allowed."

There is, however, no indication in any of these cases that the result of under-reporting will not be enforced.

II

The Judgment Below Disregards The Language of The Policy Involved Here

After noticing the theory of reporting policies—that they carry with them their own penalty for under-reporting, a diminution in the amount of the insurance recoverable—we return to the specific language involved in the present policy. We have seen that paragraph 3 reads as follows:

> "The insured expressly agrees to file with the insurer * * * a true statement in writing of the value of the stock covered hereunder * * * and the

> amount of any non-provisional insurance on any stock against the hazards covered hereunder."

It is admitted that the values reported were correct, that the assured reported $50,000.00 of non-provisional insurance, and that in fact it only had $33,333.33.

In the case already mentioned of *Automobile Insurance Co. vs. Barnes-Manly Wet Wash Laundry Co.,* 168 F. 2d 381, decided by the United States Court of Appeals for the Tenth Circuit on April 30, 1948, that Court had for consideration a reporting form of policy in which it was provided as follows:

> "The Assured agrees to maintain and keep an accurate record of its business, and on or before the 10th day of each month to report to this company the total amount of its gross receipts (either collected or uncollected) from its business during the preceding month or such time as is within the policy period.

Of this provision Circuit Judge Phillips, speaking for the Court, said:

> "The provision of the policy by which the Laundry Company agreed to maintain and keep an accurate record of its business and on or before the 10th day of each month report to the Insurance Company the total amount of its gross receipts from business during the preceding month was a promissory warranty. That promissory warranty the Laundry Company breached, but it afforded no ground for the cancellation of the policy because the Insurance Company affirmed the contract by continuing to pay the loss claims after knowledge of the fraud."

The fact that there was admitted fraud in the case

from which we have just quoted makes no difference in whether the provision of the policy was a promissory warranty. In our case although we firmly believe that the obligation to report truly the value of the stock on hand each Saturday in each month and the amount of any non-provisional insurance is a promissory warranty, we agree that the policy is not avoided for breach of the warranty, except perhaps in a clear case of fraud. In fact, it was not intended when the policy was prepared that an innocent report of values should work a forfeiture. The insurer in this instance did not intend when it drafted the form and it made no contention at any time during the determination of the loss or the pendency of this litigation that the filing of a report which was not a "true statement" would avoid its liability. It did contend and does contend that the report limits its liability because the insurer ought not to be required to furnish insurance for which the insured is not paying any premium.

Through the filing of the report of values under Paragraph 3 the insured orders such insurance as it wants. Unfortunately, if it makes a mistake it may not get all of the insurance that it wishes to have, but it gets the amount of insurance which it orders. And it has the right to make any change in its reports prior to a fire. So we do not believe that this case may be decided by the simple determination of whether any of the clauses in the policy were promissory warranties.

The consequences of a breach of the promissory warranty, whether it is material or not, is generally

accepted to be the breach of the contract. Here by agreement between the parties it is given a different consequence. By the filing of a statement in which the values reported are excessive, the assured pays a premium for something that it does not get. By the erroneous overstatement of the amount of its non-provisional insurance it reduces the amount of coverage under the provisional policy. It gets exactly what it asks for which, unfortunately, is an amount of insurance too little for its needs but which is the amount of insurance which it ordered and for which it agreed to pay. Under the policy sued upon in this case it is specifically agreed that no premium shall be charged on any value protected by non-provisional insurance. The assured could not be made to pay on an anniversary date for more insurance coverage than it obtained through the subtraction from its report of values on hand of the amount of non-provisional insurance, whether the amount of non-provisional insurance reported was accurate or not. (Par. 7, Tr. 22).

Having eliminated the harsh penalty for forfeiture for breach of a promissory warranty, the insurer should not be penalized and this contract, fair between the parties and unambiguous, should be enforced as written. The trial judge has made an entirely different contract through his ruling than the one entered into by the parties.

This Honorable Court recently affirmed a judgment entered in the trial court in the case of *Wallace vs. World Fire & Marine Insurance Company of Hartford,*

70 F. Supp. 193, saying (166 F. 2d 571):

> "On the grounds and for the reasons stated in its opinion * * * the judgment of the District Court is affirmed."

In relation to the result of under-reporting imposed by the reporting form of policy, the trial court said in that case:

> "Where he diminishes his premium, he diminishes his potential recovery."

And he said also:

> "They cannot blow cold when their figures are to be used to compute premiums, and blow hot when they are to be relied on to compute the company's liability."

III

The Consequence of The Untrue Statement of The Amount of Non-Provisional Insurance Is To Reduce The Amount of Insurance Available to The Insured

The policy being provisional in character and affording only a provisional amount of insurance, contains a formula for the determination of the amount of insurance at the time of a loss. It is found in Paragraph 5 of the form. We have set forth this paragraph in the statement of the case and we have also set forth the appellant's computation and application of this formula to the admitted figures, and for that reason we will not set them forth again.

We feel, however, that one of the most striking results of the application of this formula is that the insured actually had values on hand on January 9, 1947, not covered by specific (or "non-provisional") insurance in the amount of $120,260.16 (Tr. 34). By virtue of having reported $50,000.00 of specific insurance, the net values which he reported to appellant were $103,593.49. Obviously, it under-reported as to value in the amount of $16,666.67, and, unfortunately for it, was also under-insured to that extent. The premium, however, is based on that report, so that the insured is getting just what it intended to pay for.

We ask this Honorable Court to examine the forms furnished to the appellee by the appellant to be used in making its monthly report (Defts.'s Ex. 22, the originals of which were transmitted). This form starts out by saying:

> "Following is a true statement of the actual cash values of all stocks * * * and all non-provisional fire insurance on such stock."

In the lower left hand corner, in large red letters, is the statement: "Under-reporting means under-insurance."

In this particular case appellant had also written to the appellee twice before the fire explaining to it the necessity of reporting accurately values and non-provisional insurance. (Deft.'s Ex. 25, Tr. 48, Deft.'s Ex. 26, Tr. 49).

By applying the formula set forth in paragraph 5 of the form, we first determine that the assured had a value of $121,410.31. (This is agreed to by both parties).

It had reported values for November of $103,593.49. ($153,593.49—the average of the values on hand on each Saturday of the month—less $50,000.00 on non-provisional or specific insurance as reported). Actually the value on hand was $153,593.40 less $33,333.33 of specific insurance—or $120,260.16. Subtracting the value reported from the actual value ($120.260.16—$103,-593.40) we get, of course, $16,666.67 as the amount of value unreported to the appellant.

We have an agreed loss of $121,410.31.

The calculation, therefore, of the amount of insurance is as follows:

Actual value of stock on hand January 9, 1947		$121,410.31
Actual non-provisional insurance		33,333.33
		88,076.98
Average Values on hand in November	$153,593.49	
Non-provisional insurance in force	33,333.33	
Actual values not covered by non-provisional insurance	$120,260.16	
Average values on hand in November	$153,593.49	
Non-provisional insurance reported	50,000.00	

Values reported for insurance and premium purposes	103,593.49	
Values under-reported		16,666.67
Amount of insurance under appellant's policy		$71,410.31

This amount appellant paid long ago and thereby discharged its entire obligation from the policy. There can be nothing more due.

There has not been a great deal of litigation involving the provisional or reporting form of insurance policy. It is a good policy, as we have said, tailored to the needs of the business man with a stock which fluctuates in value. It doesn't seem an unreasonable task to require the insured to report accurately his values and his non-provisional or specific insurance, nor does it seem that the insurance company has been harsh in saying your policy shall not be breached by the failure to report honestly, but you will not have, upon the happening of a loss, any more insurance than you have ordered and agreed to pay for, and you may not change the amount of insurance after the happening of a loss. Not only is the insured permitted by Paragraph 3 of the form to include in his report of values and estimate sufficient to cover errors or omissions (Par. 3, Tr. 20), but he is given the absolute privilege of making "any changes desired by him in the last previously filed statement re-

quired in Paragraph 3, if the changes are made in writing and filed before a loss shall have occurred." (Par. 8, Tr. 23.)

In this case it is clear that the statement rendered under Paragraph 3 of the "standard provisional stock form" is the basis upon which the premium is to be computed, except that if a loss occurs a premium for the unexpired portion of the policy here, based upon the amount of loss paid, shall at once be due and payable (Par. 9, Tr. 23). The premium earned prior to loss is definitely determinable by Paragraph 7 from the statement filed under Paragraph 3. Paragraph 7 (Tr. 22) refers not only to the "Average of Values filed with this Insurer" but also provides that no premium shall be charged "on any value protected by non-provisional insurance against the hazards covered hereunder *reported in accordance with paragraph 3.*" There is no provision for an audit and it appears from the four corners of the policy that the premium is to be determined upon the basis of the report made under paragraph 3. This report is under oath and includes the report of "the amount of any non-provisional insurance on said stock against the hazards covered hereunder." (Tr. 20.)

To hold, as the trial judge held in this case, that in the event of over-statement in the amount of non-provisional insurance the insurer's only remedy is to recover the unpaid premium, does violence to the sound reasoning of Circuit Judge Phillips of the Tenth Circuit in *Automobile Insurance Co. vs. Barnes-Manly Wet Wash*

Laundry Co., 168 F. (2d) 381 (1948), where he said, page 385:

> "The judgment for the unpaid premiums in no wise compensated the Insurance Company for the fraud."

Paraphrasing that language, the judgment for the unpaid premiums in the present case no wise compensates the insurance company for the increase of its hazard through permitting the insured to change its report after a loss has occurred.

The privilege given by paragraph 8 "to make any changes desired by him in the last previously filed statement required in paragraph 3" is subject to the express limitation which follows, "but such changes shall not be effective unless made in writing and filed with this insurer or its designated agent before a loss shall have occurred." (Tr. 23.)

The effect of the judgment in this case is to permit the insured to make a change in its statement after a loss has occurred and thus to re-write the contract between the parties.

We submit that the judgment based upon the erroneous reasoning should be reversed.

CONCLUSION

For the reason that the appellee ordered but $71,-410.31 of insurance from the appellant, which amount, adjusted slightly on account of salvage, has been paid, the judgment of the lower court should be reversed.

Respectfully submitted,

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